2011. MACs will be fully operational in distinct, nonoverlapping geographic jurisdictions by October 1, 2011.

(b) *Scope.* This subpart specifies the requirements under which providers and suppliers will be assigned to MACs.

§421.401 Definitions.

For purposes of this subpart—

Appropriate MAC means a MAC that has a contract under section 1874A of the Act to perform a particular Medicare administrative function in relation to:

(1) A particular individual entitled to benefits under Part A or enrolled under Part B, or both;

(2) A specific provider of services or supplier; or

(3) A class of providers of services or suppliers.

Medicare Administrative Contractor (MAC) means an agency, organization, or other person with a contract under section 1874A of the Act.

§421.404 Assignment of providers and suppliers to MACs.

(a) *Definitions.* As used in this section—

Chain provider means a group of two or more providers under common ownership or control.

Common control exists when an individual, a group of individuals, or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of the group of suppliers or eligible providers.

Common ownership exists when an individual, a group of individuals, or an organization possesses significant equity in the group of suppliers or eligible providers.

Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) means the types of services specified in §421.210(b).

Eligible provider means a hospital, skilled nursing facility, or critical access hospital that meets the definition of a provider under §400.202 of this chapter.

Home office means the entity that provides centralized management and administrative services to the individual providers or suppliers under common ownership and common control, such as centralized accounting, purchasing, personnel services, management direction and control, and other similar services.

Ineligible provider means a provider under §400.202 of this chapter that is not an eligible provider.

Medicare benefit category means a category of covered benefits under Part A or Part B of the Medicare program (for example, inpatient hospital services, post-hospital extended care services, and physicians'services).

Provider has the same meaning as specified under §400.202 of this chapter.

Qualified chain provider means a chain provider comprised of—

(1) 10 or more eligible providers collectively totaling 500 or more certified beds; or

(2) 5 or more eligible providers collectively totaling 300 or more certified beds, with eligible providers in 3 or more contiguous States.

Supplier has the same meaning as specified in §400.202 of this chapter.

(b) *Assignment of providers to MACs.* (1) Providers enroll with and receive Medicare payment and other Medicare services from the MAC contracted by CMS to administer claims for the Medicare benefit category applicable to the provider's covered services for the geographic locale in which the provider is physically located.

(2) Qualified chain providers may request and receive an exception from the requirement of paragraph (b)(1) of this section from CMS. Upon CMS'approval, a qualified chain provider may enroll with and bill on behalf of the eligible providers under its common ownership or common control to the MAC contracted by CMS to administer claims for the Medicare benefit category applicable to the eligible providers'covered services for the geographic locale in which the qualified chain provider's home office is physically located.

(3) As MAC contractors become available, qualified chain providers, granted approval by CMS to enroll with and bill a single intermediary on behalf of their eligible member providers prior to October 1, 2005, will be assigned at an appropriate time to the MAC contracted by CMS to administer claims for the applicable Medicare benefit category for the geographic locale in which the

chain provider's home office is physically located. The qualified chain provider will not need to request an exception to the requirement of paragraph (b)(1) of this section in order for this assignment to take effect.

(4) CMS may grant an exception to the requirement of paragraph (b)(1) of this section to eligible providers that are not under the common ownership or common control of a qualified chain provider, as well as ineligible providers, only if CMS finds the exception will support the implementation of MACs or will serve some other compelling interest of the Medicare program.

(c) *Assignment of suppliers to MACs.* (1) Suppliers, including physicians and other practitioners, but excluding suppliers of DMEPOS, enroll with and receive Medicare payment and other Medicare services from the MAC contracted by CMS to administer claims for the Medicare benefit category applicable to the supplier's covered services for the geographic locale in which the supplier furnished such services.

(2) Suppliers of DMEPOS receive Medicare payment and other Medicare services from the MAC assigned to administer claims for DMEPOS for the regional area in which the beneficiary receiving the DMEPOS resides. The terms of §§ 421.210 and 421.212 continue to apply to suppliers of DMEPOS.

(3) CMS may allow a group of ESRD suppliers under common ownership and common control to enroll with the MAC contracted by CMS to administer ESRD claims for the geographic locale in which the group's home office is located only if—

(i) The group of ESRD suppliers requests such privileges; and

(ii) CMS finds the exception will support the implementation of MACs or will serve some other compelling interest of the Medicare program.

Subpart F—Medical Review

SOURCE: 73 FR 55761, Sept. 26, 2008 unless otherwise noted.

§ 421.500 Medicare review function.

CMS enters into contractual agreements with intermediaries, carriers, Medicare Administrative Contractors (MACs), and program safeguard contractors (PSCs) to perform medical review functions not for benefit integrity purposes to ensure that items or services are covered and are reasonable and necessary in accordance with Medicare coverage policies and program instructions.

§ 421.501 Definitions.

As used in this subpart—

Allowable charge means the dollar amount (including co-payment and deductibles) that the Medicare program will pay for a particular item or service.

Benefit integrity review means medical review of claim information and medical documentation focusing on addressing situations of potential fraud, waste and abuse.

Complex medical review means all medical review of claim information and medical documentation by a licensed medical professional, for a billed item or service identified by data analysis techniques or probe review to have a likelihood of sustained or high level of payment error.

Contractor, as used in this subpart, means intermediaries, carriers, Medicare Administrative Contractors (MACs), and program safeguard contractors (PSCs).

Error rate means the dollar amount of allowable charges for a particular item or service billed in error as determined by complex medical review, divided by the dollar amount of allowable charges for that medically reviewed item or service.

Initial error rate means the calculation of an error rate based on the results of a probe review prior to the initiation of complex medical review.

Medical review means the process performed by a contractor to ensure that billed items or services are covered and are reasonable and necessary as specified under section 1862(a)(1)(A) of the Act.

Nonclinician medical review staff means specially trained medical review staff not possessing the knowledge, skills, training, or medical expertise of a licensed health care professional.

Non-random prepayment complex medical review means the prepayment medical review of claim information and medical documentation, by a licensed